HILLCREST MEDICAL CENTER
PATIENT NAME: BUCHANAN JAMES D MRN: 755396
ACCT NO: 1632000004 DOB: 19620327 LOC/ROOM: /6619
DICTATING CLINICIAN: Rodgers Katie
ADMIT DATE: 11/15/2016 DISCH DATE: 01/20/2017 PAT TYPE: IN SERVICE DATE:01/20/2017
02 Discharge Summary

ATTENDING PHYSICIAN: Ziad Sous, M.D.

DISCHARGE DIAGNOSES:

1. Quadriplegia with osteomyelitis/discitis of C5 through C6 with epidural labs at C5 through C6, status post C5 and C6 anterior cervical corpectomy, C4 through C7 discectomy, cage reconstruction of corpectomy site and anterior cervical plating on 11/15/2016 by Dr. Baird with Neurosurgery. The patient was noted to have intraoperative cultures performed, which came back positive for methicillin-susceptible Staphylococcus aureus, the patient required 42 days of IV nafcillin, per Dr. Bhattarai with Infectious Disease. The patient has completed IV antibiotic treatment. The patient is working with Physical Therapy and Occupational Therapy and is showing improvement. The patient is being discharged home with home health, physical therapy and occupational therapy. Stable.

2. Depression, stable. We will discharge the patient home on citalopram and Remeron. Stable.

3. Chronic neck pain, secondary to degenerative joint disease and recent back surgery. We will discharge the patient home on current pain medication regimen. Stable.

4. Anxiety, continue current medication regimen. Stable.

5. Hypertension, controlled. We will discharge the patient home on current blood pressure medications. Stable.

6. Anemia of chronic disease, stable.

7. Disability, requiring long-term antibiotics, long-term physical therapy and occupational therapy, the patient had had over 32 nursing homes received application for placement, all were denied. The patient will be discharged home with physical therapy and occupational therapy.

DISCHARGE CONDITION: Stable.

CONSULTATIONS:

1. Dr. Baird with Neurosurgery.

2. Dr. Bhattarai with Infectious Disease.

3. Dr. Roderick Purdie with inpatient psychiatry.

PROCEDURES:

1. MRI cervical spine with and without contrast on 01/15/2016 demonstrated;

a. Severe osteomyelitis and discitis seen in C5 through C6 with destruction of the vertebral bodies at this level. There may be an abscess in the disc space here.

b. Posterior extension of the infection and discitis represent either phlegmon or early abscess formation in the anterior epidural space at C5 through C6 causing kinking of the cervical cord, but no enhancement here. Very minimal signal abnormality is present in the cervical cord.

c. Extension of the abscess and fluid as well as cellulitis in the prevertebral soft tissues at C5 through C6 and extending upward to C1 and downward to T1.

d. Neurosurgical consultation is advised.

e. No other significant foraminal extension identified elsewhere.

2. X-ray of C-spine on 11/16/2016 demonstrated limited intraoperative views of the cervical spine as described above.

3. One view chest x-ray done on 11/16/2016 demonstrated left-sided PICC line has been retracted. The tip now projects over the mid SVC in satisfactory position. No other change.

4. CT spine done on 11/17/2016 demonstrated;

a. Postsurgical changes, C4 through C7. Surgical hardware in satisfactory position.

5. CT C-spine on 11/23/2016 demonstrated;

a. Postsurgical changes, midcervical spine. Cervical hardware is intact and unchanged in position from prior study. No cervical spinal fracture is seen.

6. X-ray C-spine done on 12/23/2016 demonstrated;

a. Anterior and posterior surgical changes of midcervical spine are noted. Moderate-to-severe degenerative spondylosis seen at all midcervical levels.

BRIEF HISTORY OF PRESENT ILLNESS AND HOSPITAL COURSE: The patient is a 54-year-old Caucasian male with a recent history of an MVA on 09/16/2016. The patient was riding his bike and was hit by a car from behind. The patient spent 1.5 months in Muskogee Regional and St. John's Hospital in Tulsa for his injuries. The patient was ambulatory when he was discharged on 10/30/2016 per his report. The patient was transferred to Hillcrest Medical Center today from Wagoner Hospital due to progressive weakness over the past 2 weeks and possible cervical lesion or discitis demonstrated on CT at Wagoner Hospital. The patient stated he lost the ability to move his left arm on 11/04/2016, right arm except gross movements on 11/08/2016 and bilateral lower extremities on 11/13/2016. The patient stated he was incarcerated on 11/03/2016 and was sent from the jail to Wagoner Hospital on 11/14/2016 due to progressive weakness. The patient was complaining of an 8/10 neck pain described as throbbing, sharp, no radiation, worse with movement, better with pain medications, for the past 2 months. He denied any other associated symptoms.

The patient had an MRI of his neck and spine, which demonstrated the beginnings of a cervical epidural abscess infection, which had caused him to deteriorate significantly, which went unrecognized and untreated until he was nearly completely quadriplegic. On 11/15/2016, the patient underwent surgery by Dr. Clinton Baird of Neurosurgery in which he had at C5 and C6 anterior cervical corpectomy, C4 through C5, C5 through C6 and C6 through C7 discectomy, C4 through C7 anterior expandable cage reconstruction of corpectomy site, C4 through C7 anterior cervical plating and drainage of the cervical abscess. Following the procedure, the patient received intensive physical therapy and

occupational therapy to re-gain strength and motion in all of his extremities. The patient's abscess cultures came back positive for MSSA and the patient was treated with 42 days of IV nafcillin as directed by Infectious Disease, Dr. Bhattarai. The patient has completed all IV antibiotic requirements and has gotten stronger and more mobile and independent with physical therapy and occupational therapy while in the hospital. The information was sent to over 35 long-term care/nursing home facilities in which he was rejected from all. The patient is being required to go home with home health and physical therapy and occupational therapy. The patient is deemed stable for discharge by Neurosurgery; Infectious Disease, Dr. Bhattarai, and Internal Medicine hospitalist.

DISCHARGE PHYSICAL EXAMINATION:

VITAL SIGNS: Upon discharge, blood pressure 128/99, respiratory rate is 18, heart rate 89, temperature 36.8, 100% on room air.

LABORATORY DATA: No recent laboratory data has been drawn.

PHYSICAL EXAMINATION:

GENERAL APPEARANCE: The patient is up in the chair at bedside and does not appear to be in any acute distress.

HEAD AND EYES: Normocephalic and atraumatic. Pupils are equal, round and reactive to light and accommodation. Extraocular movements are intact and functioning normally.

EARS, NOSE, AND THROAT: Mucous membranes are pink, moist and without lesions. The patient has poor dentition. Hearing is normal to conversation.

NECK: No jugular vein distention or thyromegaly noted.

CARDIOVASCULAR: Regular rate and rhythm, normal sinus rhythm demonstrated on telemetry. Pedal pulses are palpable bilaterally at lower extremities. No bilateral lower extremity edema noted.

RESPIRATORY: Lungs are clear to auscultation, on room air, good effort.

ABDOMEN: Soft, nondistended and nontender to palpation. Bowel sounds are active x4.

MUSCULOSKELETAL: The patient is able to move all extremities, noted weakness to the left upper extremity, only gross movements are noted and the patient is unable to lift arm without assistance.

NEUROLOGICAL: Cranial nerves are intact. The patient is able to follow commands.

PSYCHIATRIC: The patient is alert and oriented x3, pleasant mood and affect.

ACTIVITY: As tolerated and as directed per home health.

DIET: Regular diet.

DISCHARGE MEDICATIONS:

1. Ascorbic acid 500 mg p.o. b.i.d.

2. Carvedilol 6.25 mg p.o. b.i.d.

3. Citalopram 20 mg p.o. daily.

4. Docusate sodium 100 mg p.o. b.i.d.

5. Pepcid 20 mg p.o. b.i.d.

6. Ferrous sulfate 325 mg p.o. b.i.d.

8. Mirtazapine 30 mg by mouth p.o. at bedtime.

9. Therapeutic multivitamin 1 tablet by mouth p.o. daily.

10. Risperidone 1 mg p.o. b.i.d. as needed for agitation.

11. Norco 10 mg/325 mg 1 tablet by mouth every 8 hours as needed for pain.

12. Xanax 1 mg p.o. daily p.r.n. for anxiety.

FOLLOWUP: The patient is to follow up with primary care provider in 1-2 weeks. The patient is to follow up with neurosurgery/neurology as needed.

DISCHARGE INSTRUCTIONS: The patient is being discharged home with home health, physical therapy and occupational therapy. The patient is to follow up as directed. The patient is to take new medications as directed. The patient does not have a primary care physician.

This discharge took greater than 30 minutes.

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Katie Rodgers CNP

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Ziad Sous MD

TR: KR/BN D: 01/20/2017 12:06:24 T: 01/20/2017 23:48:20

Job#: 145291 Doc. ID: 5658135
Electronically Authenticated by:
Katie Rodgers, CNP On 01/25/2017 05:50 PM CST
Electronically Authenticated by:
Ziad Sous MD On 01/26/2017 10:31 AM CST